Form Instructions

For Providers of Health Care Items and Services
Completion of the Advance Beneficiary Notice (CMS-R-131-G)

Upon final OMB approval of the Advance Beneficiary Notice (ABN), complete instructions will be formally published in the Medicare Carriers Manual, the Medicare Intermediary Manual, and relevant Provider Manuals. The manual instructions will be the official Medicare program promulgation of policy and procedures that providers (viz., physicians, practitioners, suppliers, and providers under Parts A and B of Medicare) and Medicare carriers and fiscal intermediaries are to follow with respect to ABNs.

i. Header of ABN--

a. Header top--Put your (provider's) name, address and telephone number at the top of the page of the notice; including your logo (if any).

b. "Patient name" Line--Enter the name of the patient; do not substitute the name of an authorized representative.

c. "Medicare # (HICN) Line--Enter the patient's Medicare health insurance claim number.

ii. Body of ABN--

a. In the section beginning "We expect that Medicare will not pay for the item(s) or service(s) …", in the first box "Items or Services:", specify the health care items or services for which you expect Medicare will not pay. The items or services at issue must be described in sufficient detail so that the patient can understand precisely what items or services may not be furnished. In the second box "Because:", give the specific reason why you expect Medicare to deny payment. The reason(s) must be sufficiently specific to allow the patient to understand the basis for your expectation that Medicare will deny payment, and, if necessary, to gather evidence to the contrary in support of the coverage of such items or services. You may customize these two boxes for your own use; any pre-printing should be in at least 12 point Arial or Arial Narrow font or a similarly readable font.

b. "Estimated Cost" Line--You may provide the patient with an estimated cost of the items and/or services.

c. Options 1 & 2 Boxes--Have the patient select an option.

d. In the "Date" blank, the patient, or person acting on his or her behalf, enters the date on which he or she signed the ABN. In the "Signature of patient …" blank, the patient, or person acting on his behalf, must sign his or her name.

iii. Disclosure--

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566.

The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection.

If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.